DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 4-8-1 OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING B. WING 02/22/2018 445306 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 215 HIGHLAND CIRCLE DRIVE SIGNATURE HEALTH OF PORTLAND REHAB & WELLNESS CENT PORTLAND, TN 37148 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) SHC of Portland does not admit that any deficiencies existed before, during, or after the survey. The facility F 000 INITIAL COMMENTS reserves all rights to contest the survey findings through IDR, formal appeal proceedings, or any administrative or A recertification survey and complaint legal proceeding. This Plan of Correction is not meant to investigation #43320 were completed on 2/22/18 establish any standard of care, contract obligation, and at Signature Healthcare of Portland. No the facility reserves all rights to raise all possible deficiencies were cited related to the complaint contentions and defenses in any type of civil or criminal investigation #43320 under 42 CFR PART 483, claim, action, or proceeding. Nothing contained in this Requirements for Long Term Care Facilities. POC should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance, or self-critical Deficiencies were cited related to the recertification survey under 42 CFR PART 483. examination priviledge which the facility does not waive and reserves the right to assert any administrative, Requirements for Long Term Care Facilities. criminal, or civil claim, action, or proceeding. The facility F 636 F 636 Comprehensive Assessments & Timing offers its credible allegation of compliance as part of its SS=D | CFR(s): 483.20(b)(1)(2)(i)(iii) ongoing effort to provide quality of care to residents. §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. What corrective action will be accomplished for those residents found to have been §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. affected by the deficient practice: A facility must make a comprehensive assessment of a resident's needs, strengths, On 2/22/18 the 14 Day Assessment for goals, life history and preferences, using the resident #53 was updated to reflect use of a resident assessment instrument (RAI) specified feeding tube. by CMS. The assessment must include at least the following: How will you identify other residents having (i) Identification and demographic information the potential to be affected by the same (ii) Customary routine. (iii) Cognitive patterns. deficient practice and what corrective action (iv) Communication. will be taken (v) Vision. (vi) Mood and behavior patterns. On 2/22/18 a 100% audit of all elders with a (vii) Psychological well-being. feeding tube was completed to ensure that (viii) Physical functioning and structural problems. their MDS Assessments reflected the use of a (ix) Continence. (x) Disease diagnosis and health conditions. feeding tube. No deficiencies were found. (xi) Dental and nutritional status. (XB) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

If continuation sheet Page 1 of 17

PRINTED: 03/02/2018

program participation.

PRINTED: 03/02/2018 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445306	B. WING _		02/	22/2018	
	PROVIDER OR SUPPLIER	RTLAND REHAB & WELLNESS C	ENT	STREET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHLAND CIRCLE DRIVE PORTLAND, TN 37148			
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	(xvi) Discharge plan (xvii) Documentation regarding the addition the care areas to the Minimum Data (xviii) Documentation assessment. The ainclude direct observith the resident, as licensed and nonlice members on all shifts (xviii) Discharge and nonlice members on all shifts (xviii) When timeframes prescribed through (iii) of this sprescribed in §413.3 apply to CAHs. (i) Within 14 calendary (ii) Within 14 calendary (iii) Within 14 calendary (iii) Within 15 candition. (For eadmission mental condition. (For eadmission mental condition.) (For eadmission mental condition. (For eadmission mental condition. (For eadmission mental condition. (For eadmission mental condition.) (For eadmission mental condition. (For eadmission mental condition.) (For eadmission mental condition. (For eadmission mental condition.) (For eadmission mental condition.) (For eadmission mental condition mental condition.) (For eadmission mental condition mental condition.)	ents and procedures. Inning. In of summary information ional assessment performed riggered by the completion of Set (MDS). In of participation in assessment process must vation and communication is well as communication with ensed direct care staff fts. In required. Subject to the bed in §413.343(b) of this just conduct a comprehensive sident in accordance with the d in paragraphs (b)(2)(i) ection. The timeframes 343(b) of this chapter do not ar days after admission, ons in which there is no in the resident's physical or or purposes of this section, is a return to the facility by absence for hospitalization	F 63	6 What measures will be put into place systematic changes you will make to that the deficient practice does not. On 2/23/18, MDS coordinators were educated by facility administrator and regional MDS Consultant that G tubes be reflected on assessments when in thow will the corrective actions(s) be monitored to ensure the deficient powill not recure: Beginning 2/26/18, a weekly list of all with a G tube will be sent to the Region MDS Consultant to ensure that assess capture use of feeding tubes. After 30 list of all elders with a G tube will be monthly to the Regional MDS Consultanter that assessments capture use feeding tubes. Beginning 2/26/18 a 1 audit of assessments of elders with a tube will be completed weekly for on followed by a 20% audit of assessment monthly for three months.	recur. ad es must adicated. l elders onal sments 0 days, a sent tant to of 00% feeding e month,	3/12/18	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event (D: PX4511

Facility ID: TN8305

If continuation sheet Page 2 of 17

PRINTED: 03/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		445306	B. WING _		02/22/2018
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	admitted to the face readmitted 1/17/18 Failure to Thrive, V Dysphagia Oropha Anxiety Disorder, C Hypertension and C Disease. Medical record revipata Set (MDS) da #53 had short and was totally dependented in the continued review record review recording at Continued review recording at the continued recording at	iew revealed Resident #53 was ility on 12/30/17 and with diagnoses including Adult (itamin D Deficiency, ryngeal Phase, Schlzophrenia, Chronic Kidney Disease, Gastro-esophageal Reflux Tew of the 14-day Minimum ted 1/31/18 revealed Resident long term memory problems, ent for eating, transfers, bed and Activities of Daily Living. evealed the resident was not of a feeding tube which was	F 63	166	
	1/4/18 revealed "[continues to have of therapy and does n well. He is at risk fo have referred him for Endoscopic Gastros be inserted as soon review of a Progres was sent to the local returned to the facil of a Physician's Ord "INCREASE TUBI [milliliters] AN HOUI GOAL RATE OF 60 Interview with MDS	ew of a Progress Note dated named Resident #53] ifficulty working with speech of appear to be swallowing raspiration and weight loss. If or a PEG [Percutaneous sotomy; feeding tube] tube to as possible" Continued s Note revealed Resident #53 at hospital on 1/9/18 and ity on 1/17/18. Further review ler Sheet revealed E FEEDING BY 10 ML REVERY 6 HOURS UNTIL ML IS REACHED"			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PX4511

Facility ID: TN8305

If continuation sheet Page 3 of 17

PRINTED: 03/02/2018 FORM APPROVED OMB NO. 0938-0391

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		445306	B. WING	· · · · · · · · · · · · · · · · · · ·	02/22/2018
	SUMMARY STA	TLAND REHAB & WELLNESS CI TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ENT ID PREFE) TAG	STREET ADDRESS, CITY, STATE, ZIP COI 215 HIGHLAND CIRCLE DRIVE PORTLAND, TN 37148 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION (X5) HOULD BE COMPLETION
F 640 SS=D	Resident #53. RN # have a feeding tube accurately assess F feeding fube which medical record doct on the 14-day MDS. Encoding/Transmitti CFR(s): 483.20(f)(1) \$483.20(f) Automate requirement-\$483.20(f)(1) Encode a facility completes facility must encode each resident in the (i) Admission assess (ii) Significant chang (iv) Quarterly review (v) A subset of items reentry, discharge, a (vi) Background (facility must be cap GMS System information and facility must be cap CMS System information and that passes star CMS and the State. \$483.20(f)(3) Transmitted and that passes star CMS and the State.	pleting the 14-day MDS for 1 confirmed the resident does and the facility failed to desident #53 for the need of a was evident through other umentation and not reflected ing Resident Assessments (a)-(4) and data processing data. Within 7 days after a resident's assessment, a the following information for facility: sment. The ent updates of the status assessments assessments. The supon a resident's transfer, and death. The evident does not be a specific transfer, and death. The evident does not be resident's transfer, and death. The evident does not be resident's transfer, and death. The evident does not be resident's transfer, and death. The evident does not be resident's transfer, and death. The evident does not be resident's transfer, and the evident does not be resident does not be resi	F 6		ave been ice: cking record d. sidents having the same rrective action it of all elders x months was leath tracking o place/What ake to ensure s not recur. ators were strator and he MDS death

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:PX4511

Facility ID: TN8305

If continuation sheet Page 4 of 17

PRINTED: 03/02/2018 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (COMPLETED IN COMPLETED IN COMPLET		1PLETED		
4	445306	B. WING		02/	22/2018
1 ALBUMAN AND	TLAND REHAB & WELLNESS C	ENT	STREET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHLAND CIRCLE DRIVE PORTLAND, TN 37148 PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREEIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL OF THE STATE O	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETION DATE
(ii) Admission assessive (iii) Annual assessment (iii) Significant correct (v) Significant correct (v) Significant correct (v) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, a (viii) Background (fact initial transmission of does not have an additional transmit data in the form a State which has by CMS, in the formal approved by CMS. This REQUIREMENT by: Based on medical rest the facility failed to transmit death transmit for 1 resident (#1) of Findings include: Medical record review admitted to the facility including Dementia, F Syndrome, and Deprivate and Deprivate and Tecord review admitted the resident on 12/19/17. Medical record review admitted record review admitted the resident on 12/19/17.	cluding the following: ment. ent. ge in status assessment. ction of prior full assessment. ction of prior quarterly s upon a resident's transfer, and death. ce-sheet) information, for an f MDS data on resident that mission assessment. cormat. The facility must format specified by CMS or, an alternate RAI approved at specified by the State and T is not met as evidenced ecord review and interview, ansmit the Minimum Data cking record within 14 days 29 residents reviewed. Av revealed Resident #1 was y on 6/3/14 with diagnoses Heart Failure, Chronic Pain ession. Continued review passed away in the facility v of the MDS Nursing Home sing Item Set dated 12/19/17	F 640	How will the corrective actions(s) a monitored to ensure the deficient will nor recur: Beginning on 2/23/18 the facility administrator will sign off on the M Assessment report in SimpleLTC, M report from IHN(both active and intensure they are marked transmittal audit will continue weekly for 30 da and then monthly for three months of the audits will be reviewed in the QAPI meeting to ensure compliance deficient practice will be corrected immediately.	issing DS status active) to ole. This ys days . Results	3/12/18

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PX4511

Facility ID: TN8305

If continuation sheet Page 5 of 17

PRINTED: 03/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTH OF PORTLAND REHA	AB & WELLNESS C	- I	STREET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHLAND CIRCLE DRIVE PORTLAND, TN 37148		
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Interview with MDS Coordinator 12:06 PM in her office revealed passed away on 12/19/17. Contirevealed the MDS death tracking been transmitted as of this date, the MDS Coordinator confirmed to transmit the MDS death tracking required 14 days. F 657 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care §483.21(b)(2) A comprehensive be- (i) Developed within 7 days after the comprehensive assessment (ii) Prepared by an interdisciplinal includes but is not limited to- (A) The attending physician. (B) A registered nurse with responsibility resident. (C) A nurse aide with responsibility resident. (D) A member of food and nutritif (E) To the extent practicable, the the resident and the resident's read and their resident representative not practicable for the developm resident's care plan. (F) Other appropriate staff or prodisciplines as determined by the or as requested by the resident. (iii) Reviewed and revised by the team after each assessment, incomprehensive and quarterly revassessments.	Resident #1 Inued interview or record had not Further interview the facility failed ing record in the Plans care plan must completion of ary team, that consibility for the lity for the lity for the resident's n of the resident is determined ent of the offessionals in resident's needs interdisciplinary cluding both the		The country of the co	s having ame re action tration ensure post fall. O days opriate in to aid ins will	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PX4511

Facility ID: TN8305

If continuation sheet Page 6 of 17

PRINTED: 03/02/2018 FORM APPROVED OMB NO. 0938-0391

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	by: Based on facility por and interview, the far plan for 1 resident (in Findings include: Review of the facility 6/1/2015 revealed " reviewed following eand with each significant to be revised as assessment" Medical record reviewed admitted to the facility including Dementiany Disturbances, Hypogramed Need Assistance (MDS) date (MDS	licy, medical record review, cility failed to update the care #52) of 29 reviewed. If policy for "Falls" dated and the care plan will be ach fall, quarterly, annually, cant change. Interventions indicated by the If we revealed Resident #52 was by on 7/19/17 with diagnoses without Behavioral plycemia, Bradycardia, chalopathy, History of Falls, with Personal Care. If we of the Quarterly Minimum and 10/24/17 revealed Brief Interview for Mental adicating severe cognitive If we of the facility investigation and fell off of it" with diagnose the can and fell off of it" with diagnose the can and fell off of it"	F 65	What measures will be put into place systematic changes you will make to that the deficient practice does not a Beginning on 2-22-18 Nursing Administrated education regarding the needensure that the care plan is updated a fall. On-going education will continuachieve compliance. During the Daily Clinical Meeting (More Friday) a review of each fall occurrent done and care plan will be checked to appropriate intervention is in place. Education started on 2-22-18 to the Normal Staff that following an event they must update the care plan and ensure that intervention is appropriate. The nurs have been educated to call the Admin Nurse on call to guide them through the process as necessary. If non-compliar identified re-education will occur with progressive discipline as needed. A reweekly falls will be done in the weekly meeting with the Elder's chart to ensure the intervention remains effective an care plan as an updated intervention.	ensure recur. stration to following ue to nday- ce will be ensure lursing st ing staff istrative he nce is view of colinical are that d on the		

Event ID: PX4511

front of her basin. Trash can was turned on side

PRINTED: 03/02/2018 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445306	B. WING _		02/	22/2018	
,	PROVIDER OR SUPPLIE	R ORTLAND REHAB & WELLNESS CI	ENT	STREET ADDRESS, CITY, STATE, ZIP CO 215 HIGHLAND CIRCLE DRIVE PORTLAND, TN 37148			
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F 657	Medical record rewas not updated vintervention related Interview with LPN the sitting room rebalance" unless hencouraged to sit my exit seekers". Interview with LPN the nurse's station in her room on 9/2 trash can to "pee a Resident #52 had previously 9/29/17 "Resident #52 get and if you walk with become combative	der stated she was attempting to and it turned over" view of the Care Plan revealed it with a new a new fall d to incident or at all. I #2 on 2/21/18 at 1:33 PM in evealed Resident #52 had "good er back was hurting; down. Resident #52 "is one of #3 on 2/22/18 at 2:43 PM at #2 revealed Resident #52 was 19/17, she got up and sat on the end poop" and lost her balance exhibited these behaviors. Continued interview revealed is up and walks when she wants her sometimes she can	F 65	How will the corrective action monitored to ensure the defice will nor recur: Beginning on 3-2-18 members committee will review the effet the systematic changes and rewith interventions listed on the ensure compliance is achieved then monthly x 3 months.	of the QA&A ctiveness of view of falls e care plans to	3/12/18	
	2/22/18 at 2:51 PM revealed Resident bathroom by herse the only time she re	If at the nurse's station #2 #52 ambulates to the If. Further interview revealed needs assistance is when her Resident #52 refuses care at					
The second section is a second	2/22/18 at 3:40 PN staff was aware of confusion of using Continued interview	Director of Nursing (DON) on I in her office revealed that Resident #52's falls relating to the trash can as a toilet. W with the DON confirmed the late the care plan for Resident					

Event ID: PX4511

PRINTED: 03/02/2018 FORM APPROVED OMB NO. 0938-0391

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AND PLAN (OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILD	ING			
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NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 15 HIGHLAND CIRCLE DRIVE		
SIGNATI	JRE HEALTH OF POR	TLAND REHAB & WELLNESS C	ENT		PORTLAND, TN 37148		ga .
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F 689	CFR(s): 483.25(d)(1 §483.25(d) Accident The facility must enson §483.25(d)(1) The mas free of accident h	zards/Supervision/Devices ()(2) (s. (sure that - esident environment remains hazards as is possible; and			What corrective action will be accomply for those residents found to have been affected by the deficient practice: On. 2-22-28 the DON and Nursing Administration reviewed the care plant Resident (#52) and it was updated to the current needs of the Resident. The	n for reflect ne	
	supervision and ass accidents. This REQUIREMEN by: Based on facility po and interview, the fa	resident receives adequate istance devices to prevent T is not met as evidenced licy, medical record review, cility failed to maintain a safe sident (#52) of 29 reviewed.			nursing Administration team assessed Elder's room on 2-22-18 to ensure a senvironment. How will you identify other residents	afe having	
	6/1/2015 revealed ". reviewed following e and with each signifi are to be revised as Falls resulting from e reviewed at monthly	policy for "Falls" datedThe care plan will be ach fall, quarterly, annually, cant change. Interventions indicated by the assessment. environmental factors will be Safety Committee"			the potential to be affected by the saideficient practice and what corrective will be taken Beginning on 3-5-17, Nursing Administreviewed current Elder's care Plan an assessed her room for safety concern noted concern was corrected. Elders have fallen within the last 90 days will	e action stration d s, any that	
to the second se	admitted to the facilit including Dementia volution Distubances, Hypogle Hypertension, Encepand Need Assistance Medical record review Data Set (MDS) date Resident #52 had a legisted including the second review of the se	ycemia, Bradycardia, halopathy, History of Falls, with Personal Care. w of the Quarterly Minimum		***************************************	reviewed and will have their room/environment checked for safet concerns and corrected as needed. A audit will be completed on all Elder's and common areas to assess for safet concerns and corrected as needed. V during rounding the safety needs of t Elders will be assessed per Administration.	ty Veekly	d

Facility ID: TNB305

		(X3) DATE SURVEY COMPLETED			
		445306	B. WING		02/22/2018
	PROVIDER OR SUPPLIER JRE HEALTH OF POR	TLAND REHAB & WELLNESS CI	ENT 2	STREET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHLAND CIRCLE DRIVE PORTLAND, TN 37148	
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F 689	Continued From pa	ge 9	F 689	corrected as needed, beginning 3-9-1	8.
	dated 9/29/17 reveal bathroom in the tras	ew of the facility investigation aled "Resident used the sh can and fell off of it" ew of the Care Plan revealed it th a new a new fall		What measures will be put into place systematic changes you will make to that the deficient practice does not reached. Beginning on 3-5-18 Nursing Adminis	ensure ecur.
	this nurse [Licensed and observed elder her pants down in fr was turned on side a	ew of the the facility 11/26/17 revealed "CNA and I Practical Nurse #3] room sitting in the floor in urine with ont of her basin. Trash can at elder's side. Elder stated to use the bathroom and It		started education regarding safety an environment for our Elders. Beginnin 9-18 the Administrative team will beg rounding 3 times weekly to observe for concerns and will correct any concern identified. On-going education will coto achieve compliance.	g on 3- in round or safety as
SS=D	the nurse's station 2 in her room on 9/29/trash can to "pee an Resident #52 had expreviously 9/29/17. Interview with the Di 2/22/18 at 3:40 PM is staff was aware of R confusion of using the Continued interview facility failed to main Resident #52. Drug Regimen Revie CFR(s): 483.45(c)(1) \$483.45(c) Drug Regimen Revie CFR(s): 483.45(c) Drug Regimen Revier Revier Revier Regimen Regi		F 756	How will the corrective actions(s) be monitored to ensure the deficient prawill nor recur: Beginning on 3-2-18 members of the committee will review the effectivene the systematic changes and review an concerns to ensure compliance is achi 30 days and then monthly x 3 months	QA&A ess of y safety eved x 3/12/18
	must be reviewed at	least once a month by a		ut to widous to the continueti	on chast Page 10 of 17
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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E 750	G. Saved Frances	10		756	What corrective action will be accom	plished	
	Continued From pa	- · · · · · · · · · · · · · · · · · · ·	F	00	for those residents found to have be	en	
165	licensed pharmacis	L HOSE			affected by the deficient practice:	i	
	§483.45(c)(2) This	review must include a review			a a a a a a a a a a a a a a a a a a a		
	of the resident's me	dical chart.			On. 2-22-28 the DON reviewed the Dr	1	
	0.400 45(.)(4) The	to a man a sind manual and a manual arms			Regimen Review for Resident #53, co		
		pharmacist must report any attending physician and the			was made with the MD and an approp	i	
		ector and director of nursing,			response was obtained to correctly id		
	and these reports m				the need that was recommended on t Regimen Review. The order was obta		
		ude, but are not limited to, any criteria set forth in paragraph		33	and written and the Elder's care plan	- 3	
		r an unnecessary drug.		= 8	updated to reflect the current needs	123	
	(ii) Any irregularities	noted by the pharmacist		ğ	Elder.	, are	
	during this review m	nust be documented on a			cider.		
į	separate, written rep	oort that is sent to the and the facility's medical		18	How will you identify other residents	having	
	director and director	of nursing and lists, at a		18	the potential to be affected by the sa	me	
	minimum, the reside	ent's name, the relevant drug,			deficient practice and what correctiv	e action	
# # # # # # # # # # # # # # # # # # #	(iii) The attending pl	the pharmacist identified. hysician must document in the		1	will be taken	İ	
	resident's medical r	ecord that the identified			Beginning on 2-22-18, Nursing Admin	stration	
	action has been tak	n reviewed and what, if any, en to address it. If there is to			reviewed current /drug Regimen Revi contacted the attending MDs and obta	ew and ained	
	pe no change in the	medication, the attending cument his or her rationale in			orders as needed to ensure the Drug F		
	the resident's medic	al record.			Review was followed or if not appropr		
į	20 51 51 9223 (2005) (40				documentation was made for risk vers	es	
i	maintain policies an	acility must develop and d procedures for the monthly			benefit.	Andrew State Company	
	drug regimen review	v that include, but are not es for the different steps in			What measures will be put into place	/What	
į	the process and ste	ps the pharmacist must take			systematic changes you will make to	ensure	
	when he or she iden	tifies an irregularity that			that the deficient practice does not re	cur.	
į	requires urgent action	on to protect the resident. IT is not met as evidenced					
t t	Inis REQUIREMEN by:	It is the thier as evidenced					
1	Based on medical r	ecord review and interview, ensure a documented			87	- Andrews	
100		1		113	544	0.2	RI I

CENTE	43 FOR WEDICARE	A MEDICAID SLINVICES			0.00 0.00	C 01 (D) (C) (
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION		E SURVEY IPLETED
		445306	B. WING		02/	22/2018
	PROVIDER OR SUPPLIER JRE HEALTH OF POR	TLAND REHAB & WELLNESS CI	ENT	STREET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHLAND CIRCLE DRIVE PORTLAND, TN 37148		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRIES OF THE APP	JLD BE	(X5) COMPLETION DATE
F 758	reviewed. Findings include: Medical record revie admitted to the facil 1/17/18 with diagno Thrive, Vitamin D D Anxiety Disorder and Medical record revie Data Set (MDS) dat #53 had short and the Continued review rereceived antianxiety look-back period. Medical record review rereceived antianxiety look-back period. Medical record review Review dated 1/8/18 PRN [as needed] meen used in this real-8) based on mar [Record]. Please conneed or discontinual [antianxiety medical revealed the documattending physiclan was chosen by the place of the Medical review for Regimen Review for the Medical review for Regimen Review for the Medical review for Regimen Review for the Medical record review for the Medical record review for the Medical re	ew revealed Resident #53 was ity 12/30/17 and readmitted ses including Adult Failure to efficiency, Schizophrenia, d Major Depressive Disorder. ew of the 14-day Minimum ed 1/31/18 revealed Resident ong term memory problems. evealed the resident had medication during the edication(s) has/have not sident during the month (Jan Medication Administration insider evaluation of continued thonMedication(s): diazepam ion]" Further review ent was signed by the on 1/18/18 but no response ohysician. Irrector of Nursing (DON) on the conference room, Medication Regimen Review, of failed to ensure a se was given to a Medication resident #53.	F7	Beginning on 3-9-18 Nursing Admi will review the Drug Regimen Review the weekly clinical review meeting appropriate responses are being of are documented on each Drug Regimen. The MDs will be educated response and appropriate docume "Risk Verses Benefit" as needed on the education will be completed by How will the corrective actions(s) monitored to ensure the deficient will nor recur: Beginning on 3-2-18 members of the committee will review the effective the systematic changes; a review the Regimen Review for appropriate acts be completed during the meeting xeand then monthly x 3 months.	ew during to ensure btained and imen on ntation of the DRR, 3-31-18. be practice he QA&A ness of the Drug tions will	d 3/12/18

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING.			Vi.
	445306	B. WING			02/2	22/2018
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTH OF POR	TLAND REHAB & WELLNESS C	ENT	2′	TREET ADDRESS, CITY, STATE, ZIP CODE 15 HIGHLAND CIRCLE DRIVE ORTLAND, TN 37148		*
CREEK FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
affects brain activities processes and behabut are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compres resident, the facility §483.45(e)(1) Reside psychotropic drugs unless the medication as in the clinical record drugs receive gradule behavioral intervent contraindicated, in a drugs; §483.45(e)(3) Reside psychotropic drugs unless that medication drugs; §483.45(e)(3) Reside psychotropic drugs unless that medication drugs; §483.45(e)(4) PRN (are limited to 14 day §483.45(e)(5), if the prescribing practition practition drugs processes and behavioral; [1] Anti-psychotic; [2] Anti-psychotics [3] Anti-depressant; [3] Anti-depressant; [4] Anti-depressant; [5] Anti-depressant; [6] Anti-depressant; [6] Anti-depressant; [6] Anti-depressant; [7] Anti-depressant; [8] Anti-depressant; [9] A	ropic Drugs. chotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following thensive assessment of a must ensure that lents who have not used are not given these drugs on is necessary to treat a diagnosed and documented in effort to discontinue these drugs on effort to discontinue these drugs on is necessary to treat a sent do not receive pursuant to a PRN order on is necessary to treat a condition that is documented	F7		What corrective action will be accomfor those residents found to have be affected by the deficient practice: On. 2-22-18 the DON and Nursing Administration reviewed Resident # 561 physician orders with respect to psychotropic medications. The MD we contacted and orders were obtained correct the concern. How will you identify other residents the potential to be affected by the sadeficient practice and what corrective will be taken Beginning on 2-22-18, Nursing Admindid a 100 % audit on orders for PRN psychotropic medications, the MD was notified and an updated order was reto schedule the medication routinely, discontinue the medication or to put stop date. As these medications commenewed the MD will assess for "Risk Benefits" and document the continue or discontinue the medication. The mestaff have been educated on the proceeding of the process of	en 53 and # 7as to s having ame re action istration as ceived , to a 14 day action at the belowerses and need aursing	

CENTERS FOR MEDICARE & MEDICARD SCIAMOES				(X3) DATE SURVEY			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		445306	B. WING			02/2	22/2018
	PROVIDER OR SUPPLIER JRE HEALTH OF POR	TLAND REHAB & WELLNESS C	ENT	2	TREET ADDRESS, CITY, STATE, ZIP CODE 15 HIGHLAND CIRCLE DRIVE PORTLAND, TN 37148		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE :	(XS) COMPLETION DATE
F 758	rationale in the residenticate the duration \$483.45(e)(5) PRN drugs are limited to renewed unless the prescribing practitio the appropriateness. This REQUIREMEN by: Based on review of medical record reviet failed to ensure as medications were limited to the sidents. The limited to the starting of the previous day. The limit required to the facility in the limited to the facility. We will also the facility in the limited to the facility in the limited to the facility. We will also the facility in the limited to the facility in the limited to the facility. We will also the facility in the limited to the facility in the limited to the facility. We will also the facility in the limited to the facility in the limited to the facility. We will also the facility in the limited to the facility in the limited to the facility. We will be supported the limited to the facility in the limited to the facility. We will be supported the limited to the facility in the l	or she should document their dent's medical record and in for the PRN order. orders for anti-psychotic 14 days and cannot be attending physician or mer evaluates the resident for of that medication. IT is not met as evidenced in the pharmacy documentation, and interview the facility meded psychotropic mited to 14 days or had a le for continued use for 2 of 29 residents reviewed. PharMerica Client, and the new Daily starts Report that highlights new psychotropic drug during his new report is designed to intify PRN [as needed] sychotropic orders that have ement and insure proper policies are following for a psychotropic medications. pic New Starts Report is	F7	758	What measures will be put into place systematic changes you will make to that the deficient practice does not read the deficient practice does not responsible to the deficient regarding the needs top date on all PRN psychotropic medications, ongoing education will detempt the Daily Meeting (Monday-Friday) a review of telephone order will occur to ensure any new order for PRN psychotropic medication has a 14 day stop date or vs Benefit" documentation has been completed by the MD to continue the medication. If there is an order that meet the criteria the correction will with the MD immediately following to Clinical Meeting. If non-compliance identified re-education will occur with progressive discipline as needed. A will be completed weekly during the Clinical Review" meeting of PRN psymedications to ensure that appropri criteria is met. Any medication order not compliant with the current standard to compliance to current standards.	ensure ecur. Istration of for a continue Clinical feach that that that the does not be made the is the review ewell chotropic ate er that is dard will	t t

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	445306	B. WING	1	02/2	22/2018			
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTH OF PORTLAND REHAB & WELLNESS CI			STREET ADDRESS, CITY, STATE, ZIP CODE 215 HIGHLAND CIRCLE DRIVE PORTLAND, TN 37148					
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
Medical record reviews and short and in Continued review respectived antianxiety medication during the Medical record reviews igned by the physicular was made and in the Medical record reviews igned by the physicular was made and in the Medical record reviews igned by the physicular was made and in the Medical record reviews in the Medical record reviews order was written per tube every 4 hours was	Major Depressive Disorder. ew of the 14-day Minimum ted 1/31/18 revealed Resident ong term memory problems. evealed the resident had v and antidepressant he look-back period. ew of a Physician Order Sheet clan on 1/8/18 revealed iety medication] 5 MG PAM) TAKE 1 TABLET BY HOURS AS NEEDED" ew of a Physician Order Sheet clan on 2/6/18 revealed DIAZEPAM) TAKE 1 TABLET V 8 HOURS AS NEEDED" evealed this order was V18. Further review revealed a en 2/4/18 " Valium 5mg 1 tab urs as needed" ew of the Medication ords for January 2018 - aled Resident #61 had izepam on the following dates: 28/18, 1/31/18, 2/3-4/18, 3, 2/16/18 and 2/20/18. ew revealed no documented ttending physician to support eeded antianxiety medication	F 75	How will the corrective actions monitored to ensure the deficie will nor recur: Beginning on 3-2-18 members of committee will review the effect the systematic changes with a reproduction of the month to ensure correctness order/administration of the drug and then monthly x 3 months.	nt practice f the QA&A iveness of view of any dered during of the	3/12/18			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PX4511

Facility ID: TN8305

If continuation sheet Page 15 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		445306	B. WING		02	/22/2018	
	PROVIDER OR SUPPLIER URE HEALTH OF POR	RTLAND REHAB & WELLNESS C	ENT	STREET ADDRESS, CITY, STATE, ZIP CO 215 HIGHLAND CIRCLE DRIVE PORTLAND, TN 37148	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORK (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	medications were li documented rational Resident #53. Medical record revie admitted to the facilion 2/16/18 with diag Panic Disorder, Inscribed Transcripts of the facilion 2/16/18 with diagranic Disorder, Cognitive Chronic Obstructive Medical record revied dated 1/30/18 revealed 1/30/18 revealed antianxiety assessment look-bath Medical record revies Sheet signed by the revealed "LORAZE (LORAZEPAM) TAK BID AS NEEDED FO valid from 12/1/17 to indicated"	ure as needed antianxiety mited to 14 days or had a ale for continued use for ew revealed Resident #61 was ity on 8/24/17 and readmitted gnoses including Dementia, omnia, Major Depressive Communication Deficit and Pulmaonary Disease. Ew of the Quarterly MDS aled Resident #61 had medication during the ack period. Ew of a Physician's Order physician on 12/7/17 EPAM 0.5 MG TABLET E ONE TABLET BY MOUTH DR ANXIETYAll orders are on 12/31/17 unless otherwise w of a Physician's Order physician on 1/4/18 revealed	F7	58		p. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	
	TABLET (LORAZEP MOUTH TWICE DA	ety medication] 0.5 MG AM) ONE TABLET BY ILY AS NEEDEDAll orders to 1/31/17 unless otherwise					
	Sheet signed by the "LORAZEPAM 0.5 TAKE ONE TABLET	w of a Physician's Order physician on 2/6/18 revealed MG TABLET (LORAZEPAM) BY MOUTH TWICE DAILY NXIETYAll orders are valid 8 unless otherwise				Para landina de la companya de la co	

PRINTED: 03/02/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445306	B. WING		- COLUMN CONTRACTOR	02/	22/2018
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTH OF PORTLAND REHAB & WELLNESS CI			ENT	2′	TREET ADDRESS, CITY, STATE, ZIP CODE 15 HIGHLAND CIRCLE DRIVE ORTLAND, TN 37148		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		DOEELY /FAC		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Administration Reco February 2018 revered February 2018 revered Lorazepant dates: 12/13/17, 12/12/22-26/17, 12/30-2/16/18, 2/19/18, and Medical record revierationale from the all continuation of as no beyond 14 days for Interview with the Deher office, after review confirmed the facility antianxiety medicational a documented reserved.	ew of the Medication ords for December 2017 - aled Resident #61 had n/Ativan on the following 16/17, 12/18-19/17, 31/17, 1/12/18, 1/23/18, d 2/21-22/18.	F	758	ge		
	Resident #61.					*	

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If continuation sheet Page 17 of 17